

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
657 Chamberlin Avenue
Frankfort, KY 40601
Workers' Compensation Claim no. _____

Motion to Substitute Party and Continue Benefits

Come now the undersigned, being all dependents of the deceased Plaintiff, _____ and hereby move to be substituted as the Plaintiff herein for the purpose of receipt of benefits, and further state as follows:

1. Employee/Plaintiff: _____ SSN: _____
2. Date of death (attach copy of certified Death Certificate): _____
3. Cause of death: _____
4. Date of Award/Settlement and amount: _____
5. Name and address of party paying benefits: _____
6. Date of Marriage (attach copy of certified Marriage License): _____
7. List of dependent(s) (attach copies of certified Birth Certificates):

NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATIONSHIP	ADDRESS (city, state, zip code)

Wherefore, the dependent(s) request that he/she (they) be substituted as the Plaintiff and that said benefits be paid directly to him/her (them).

The undersigned hereby states that the foregoing is true and accurate to the best of my knowledge and belief.

Respectfully submitted,

(Signature)

Address

Relationship to decedent

Subscribed and sworn to before me by _____ on this _____ day of _____, 20____.

Notary Public, Kentucky, State at Large
My commission expires: _____

I certify that copies were mailed this _____ day of _____, 20____ to:
Employer or Attorney for Employer: _____
Other Parties (if applicable): _____

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.